Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Trophy Club Medical Center

Respondent Name
Zurich American Insurance Co

MFDR Tracking Number
M4-14-1426-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
January 22, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…billed services were denied for no authorization."

Amount in Dispute: $25,059.99

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor billed its services for February 13, 2013. That date is outside the approved length of stay."

Response Submitted by: Flahive Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 11 – 13, 2013	Inpatient Hospital Surgical Services	$25,059.99	25,059.99

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. 28 Texas Administrative Code §134.600 sets out the guidelines for prospected and concurrent review of health care.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 19/197 – Precertification/authorization/notification absent
   - 16 – Claim/service lacks information which is needed for adjudication
   - 193 – This bill is a reconsideration of a previously reviewed bill

Issues

1. Were the disputed service prior authorized?

2. Which reimbursement calculation applies to the services in dispute?
3. What is the maximum allowable reimbursement for the services in dispute?
4. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. 28 Texas Administrative Code §134.600(c) states in pertinent part "The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: …(B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care; (p) Non-emergency health care requiring preauthorization includes: (1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay;" Review of the submitted "Texas Inpatient Partial Authorization Recommendation" dated February 6, 2013. Finds: Approved Treatment: Partial Cert: C4-6 Hardware Removal/ACDF 06-7 (1 day IP). Approved Days: 1, Start Date: 1/16/2013, End Date: 3/16/2013. One day and the procedure were authorized and payable. The date span on the submitted medical claim was February 11, 2013 through February 13, 2013 which is within start and end dates shown above. Therefore; date of service February 11 (the day of surgery) will be reviewed based on Division rules and fee guidelines.
2. 28 Texas Administrative Code §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 143 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."

   Review of the documentation finds that that the facility requested separate reimbursement for implantables; for that reason, the requirements of subsection (g) apply.

3. 28 Texas Administrative Code §134.404(g) states, in pertinent part, that "(g) Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission.
   (1) A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual costs (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."

Review of the documentation found supports that the following items were certified as required by (g):

Itemized Statement Rev Code or Charge Code	Itemized Statement Description	Cost Invoice Description	# Units & Cost Per Unit	Cost Invoice Amount	***Per item*** Add-on (cost +10% or $1,000 whichever is less).
278 or other disputed (b)(2) items	Anchor Screw for opposing bone to bone or	5mm Cervical Cage	1 at $2,720.00 ea	$2,720.00	$2,992.00
278 or other disputed (b)(2) items	Anchor Screw for opposing bone to bone or	24mm 1 level cervical plate	1 at $1,500.00	$1,500.00	$1,650.00
278 or other disputed (b)(2) items	Anchor Screw for opposing bone to bone or	4x4 x14mm Variable Plate Screws	4 at $316.00 ea	$1,264.00	$1,390.40
278 or other disputed (b)(2) items	WC Bone Filler, Matrix Putty	Ultrafill DMB Putty 10cc	1 at $2,995.00	$2,995.00	$3,294.50
278 or other disputed (b)(2)	Adhesion barrier	Sterishield Amnion Patch	1 at 3,700.00 ea	$3,700.00	$4,070.00

items					
278 or other disputed (b)(2) items	Anchor Screw for opposing bone to bone or	Caspar Distr pin	2 at $80.00 each	$160.00	$176.00

$12,339.00	$13,572.90
Total Supported Cost	**Sum of Per-Item Add-on**

The division finds that the facility supported separate reimbursement for these implantables, and that the cost invoices were certified as required. Therefore, the MAR is calculated according to §134.404(f)(1)(B).

4. §134.404(f)(1)(B) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 108%, ***plus*** reimbursement for items appropriately certified under §134.404(g). The Medicare IPPS payment rates are found at http://www.cms.gov, and the sum of the per-item add-on for which separate reimbursement was requested are taken from the table above.

   - Documentation found supports that the DRG assigned to the services in dispute is 465, and that the services were provided at Baylor Medical Center at Trophy Club. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of $10,713.27. This amount multiplied by 108% results in an allowable of $11,570.33.
   - The total cost for implantables from the table above is $12,339.00. The sum of the per-billed-item add-ons does not exceed the $2000 allowed by rule; for that reason, total allowable amount for implantables is $12,339.00 plus $1,233.90, which equals $13,572.90.

   Therefore, the total allowable reimbursement for the services in dispute is $11,570.33 plus $12,339.00 which equals $25,143.23. The respondent issued payment in the amount of $0.00. The requestor is seeking $25,059.99, this amount is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $25,059.99 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October , 2014 Date
Signature	Medical Fee Dispute Resolution Manager	October , 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.